Amendment #2
To
Plan Document
And
Summary Plan Description
For
Williamson County
Deductible & Co-Pay
Employee Benefit Plan

Effective January 1, 2010, the Plan Document and Summary Plan Description for Williamson County Deductible and Co-Pay Employee Benefit Plan shall be amended to read as follows:

PRESCRIPTION DRUG BENEFIT
Summary of Benefits
Prescription coverage is included with enrollment in either the CoPay or Deductible medical programs.

MANDATORY MAIL ORDER PRESCRIPTION DRUG BENEFIT:
(90 DAYS SUPPLY)
Maintenance Prescriptions must be filled through the CVS Caremark mail service program. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled through the mail order program.

Generic drugs
Copayment.....$10

Formulary Brand Name drugs (Brand Name drugs on the Performance Drug List)
Copayment.....$40

Non-Formulary Brand Name drugs (Brand Name drugs not on the Performance Drug list)
Copayment.....$75

Pharmacy Option
(30 day supply)
For immediate and short term prescriptions, 2 30-day fills will be allowed for maintenance prescriptions at a network retail pharmacy, after 2 fills mail order is mandatory.

Generic drugs
Copayment.....$10

Formulary Brand Name drugs (Brand name drugs on the Performance Drug list)
Copayment.....$20 or 20% whichever is higher

Non-Formulary Brand name drugs (Brand name drugs not on the Performance Drug List)
Copayment.....$35 or 35% whichever is higher

Maximum $100 co-pay per prescription when purchased at retail pharmacy.

Mandatory Generic Fill.
When a Generic is available and the brand name is chosen over the generic drug, the member will pay the prescription co-payment plus the difference in the drug cots.

Caremark Specialty Pharmacy.
Specialty medications are required to be purchased through Caremark's Specialty Pharmacy. Specialty medications include biopharmaceuticals, blood-derived products, complex molecules, select oral, infused and injectable medications. For further information regarding the Specialty Program, please contact 1-866-295-2779.

Under Prescription Drug Benefits, page 44, the following section is hereby deleted:

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Caremark, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

And replaced with the following language:

Mandatory Mail Order Prescription Drug Benefit:

(90 days supply)

Maintenance Prescriptions must be filled through the CVS Caremark mail service program. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled through the mail order program.

The following section on page 64 titled, "Compliance with HIPAA Electronic Security Standards" is hereby revised to read as follows:

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information and to immediately notify the Employer of any breach of confidentiality with regard to Protected Health Information. Such security measures shall include the implementation and maintenance of reasonable and

appropriate administrative, technical, and physical safeguards to protect the security, integrity, confidentiality, and availability of Protected Health Information created, maintained, received, or transmitted by any agent or subcontractor. Any agent or subcontractor whom receives Protected Health Information pursuant to this Health Plan shall comply with additional or modified requirements set forth in any annual guidance as to the security requirements published by the Secretary of Health and Human Services and with the additional requirements of the HITECH Act that relate to security of Protected Health Information. Any agent or subcontractor who receives Protected Health Information pursuant to this Health Plan shall require any agent or subcontractor that carries out any duties for the agent or subcontractor involving the use, custody, disclosure, creation of, or access to Protected Health Information to enter into a written contract with the agent or subcontractor containing provisions substantially identical to the restrictions and conditions set forth in this paragraph.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the HIPAA Privacy Standards and the HITECH Act.

(4) In the case of a breach of Protected Health Information, the Employer shall notify each Covered Person whose unsecured Protected Health Information has been, or is reasonably believed by the Employer to have been accessed, acquired or disclosed as a result of such breach and the Employer reasonably believes that such breach poses a significant risk of financial, reputational, or other harm to the Covered Person. All notifications required under this paragraph shall be made without unreasonable delay and in no case later than sixty (60) calendar days after the discovery of a breach by the Employer. Notice under this paragraph shall be provided in the following form: (1) written notification by first-class mail to the Covered Person (or the next of kin of the Covered Person if the Covered Person is deceased) at the last known address of the Covered Person or the next of kin, respectively, or, if specified as a preference by the Covered Person, by electronic mail. (2) in the case in which there is insufficient, or out-of-date contact information (including a phone number, e-mail address, or any other form of appropriate communication) that precludes direct written notification to the Covered Person, a substitute form of notice shall be provided, including, in the case that there are ten (10) or more Covered Persons for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Department of Health and Human Services on the home page of the website of the Employer or notice in major print or broadcast media, including major media in geographic areas where the Covered Persons affected by the breach likely reside. Such a notice in media or web posting will include a toll-free phone number where a Covered Person can learn whether or not the Covered Person's unsecured Protected Health Information is possibly included in the breach; (3) in any case deemed by the Employer to require urgency because of possible imminent misuse of unsecured Protected Health Information, the Employer, in addition to written notification, may provide information to Covered Persons by telephone, or other means, as appropriate. The Employer shall also provide notice to prominent media outlets following the discovery of a breach involving unsecured Protected Health Information of more than 500 Covered Persons. Regardless of the method by which notice is provided to Covered Persons under this paragraph, notice of breach shall include, to the extent possible, the following: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (2) a description of the types of unsecured Protected Health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code); (3) the steps the Covered Persons should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what the Employer is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and (5) contact procedures for Covered Persons to ask questions or learn additional information which shall include a toll-free telephone number, an e-mail address, web site, or postal address. The Employer shall provide notice to the Secretary of the Department of Health and Human Services of any breach that requires notification to any Covered Person pursuant to this paragraph.

(5) The Employer agrees to comply with the request of any Covered Person to restrict the disclosure of his/her Protected Health Information except as otherwise required by law. The Employer further agrees to limit disclosure, use and requests of Protected Health Information, to the extent practicable, to the limited data set (as defined in the Security Standards) or, if needed by the Employer, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively.

(6) The Employer agrees to not solicit or receive any remuneration in exchange for a Covered Persons Protected Health Information unless expressly authorized by the Covered Person or permitted by the HITECH Act or its accompanying regulations. The Employer also agrees to not utilize Protected Health Information in marketing efforts unless such communications are explicitly permitted by the Security Standards.

Effective January 1st, 2010, Amendment #1 to the Plan Document and Summary Plan Description for Williamson County Co-Pay Plan Summary Employee Benefit Plan shall be clarified and reformed to reflect the original purpose and intention of Williamson County and the specific benefits illustrated as follows:

CO-PAY PLAN

Summary of Benefits

Covered Charges	
Room and Board	$350 Co-Pay
Intensive Care Unit	$350 Co-Pay
Skilled Nursing Facility	$350 Co-Pay Immediately following hospital stay
Hospice Care	$350 Co-Pay $10,000 Lifetime maximum
Mental Disorders	
Inpatient	$350 Co-Pay
Partial Hospitilization	$350 Co-Pay
Outpatient	$25 Co-Pay
Substance Abuse	
Inpatient	$350 Co-Pay
Partial Hospitalization	$350 Co-Pay
Outpatient	$25 Co-Pay

NOW, THEREFORE, the Plan shall be amended to add the following paragraphs under Eligible Classes of Dependents to comply with the new federal law commonly referred to as "Michelle's Law";

ELIGIBILITY

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age, subject to the provisions of this section.

Full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the month of the attended school term. Proof of full time student status is required each semester. Coverage will not be terminated, for a period not to exceed one year, if the student takes a medically necessary leave of absence from school or serious injury or illness requires a change to part-time status. Extension of coverage due to medically necessary leave or change of status requires certification by student's physician, in writing, that the leave or change in status is medically necessary.

Signed on February 11, 2010, in Franklin, Tennessee

Name: Rogers Anderson

Title: Mayor

Witness: Lisa Cavanaugh Date: 2/11/2010

PRESCRIPTION DRUG BENEFIT

Summary of Benefits

Prescription coverage is included with enrollment in either the CoPay or Deductible medical programs.

Mandatory Mail Order Prescription Drug Benefit:
(90 days supply)

Maintenance Prescriptions must be filled through the CVS Caremark mail service program. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled through the mail order program.

Generic drugs
Copayment $10

Formulary Brand Name drugs (Brand Name drugs on the Performance Drug List)

Copayment $40

Non-Formulary Brand Name drugs (Brand Name drugs not on the Performance Drug List)

Copayment $75

Pharmacy Option
(30 day supply)

For immediate and short term prescriptions. 2 30-day fills will be allowed for maintenance prescriptions at a network retail pharmacy, after 2 fills mail order is mandatory.

Generic drugs
Copayment $10.00

Formulary Brand Name drugs (Brand name drugs on the Performance Drug List)
Copayment ..... $20 or 20% whichever is higher

Non-Formulary Brand Name drugs (Brand Name drugs not on the Performance Drug List)
Copayment ..... $35 or 35% whichever is higher

Maximum $100 co-pay per prescription when purchased at retail pharmacy.

Mandatory Generic Fill.
When a Generic is available and the brand name is chosen over the generic drug, the member will pay the prescription co-payment plus the difference in the drug cost.

Caremark Specialty Pharmacy.
Specialty medications are required to be purchased through Caremark's Specialty Pharmacy. Specialty medications include biopharmaceuticals, blood-derived products, complex molecules, select oral, infused and injectable medications. For further information regarding the Specialty Program, please contact 1-866-295-2779.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. **Caremark** is the administrator of the pharmacy drug plan. Their Customer Service number is **800-966-5772.**

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mandatory Mail Order Prescription Drug Benefit:
(90 days supply)

Maintenance Prescriptions must be filled through the CVS Caremark mail service program. Maintenance Prescriptions are prescription drugs used on an ongoing basis. You are allowed 2 30-day fills at a network retail pharmacy for each prescription. After these 2 fills, you will need to have 90-day supply prescriptions filled through the mail order program.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin when prescribed by a Physician.

(4) Disposable insulin needles/syringes.

(5) Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape).

(6) Disposable insulin needles/syringes and/or disposable diabetic testing syringes when prescribed and dispensed at the same time as insulin will be included under the same copayment. Disposable insulin/syringes and/or disposable diabetic testing supplies must be dispensed in days supply corresponding to the amount of insulin to be dispensed and must be submitted at the same time to be included under the same copayment as the insulin.

(7) Alcohol Swabs

(8) Blood Glucose monitors.

(9) Glucose elevating agents.

(10) Lancets and lancet devices

(11) Tretinoin topical (e.g. Retin-A) for individuals through the age of 25 years.

(12) ADD/ADHD agents. Amphetamines, Methylphenidate (e.g. Ritalin) Strattera and Cyclert for individuals through the age of 18 years. Prior Authorization required for ages 19 and older.

(13) Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

(14) Legend contraceptives except for contraceptive devices.

(15) Vaccine for Shingles

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for antiobesity agents, Meridia and Xenical.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as antiwrinkle agents, pigmenting and depigmenting agents, or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance unless prior approval and determination of medical necessity is obtained through Caremark.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(19) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine patches, inhalers, nasal inhalers and oral smoking deterrents for smoking cessation.

(20) **RU486.** Mefeprex-mefaprestone.

(21) **Contraceptives.** Devices such as IUD's, diaphragms and cervical caps.

(22) **Anabolic** Steroids.

(23) **Anti-wrinkle** agents. (e.g. Renova)

(24) **Cosmetic** hair removal products.

(25) **Hair** growth stimulants.

(26) **Hematinics.**

(27) **ADD/ADHS agents.** Amphetamines, Methylphenidate (e.g. Ritalin), Strattera and Cyclert for individuals nineteen (19) years of age or older without Prior Authorization.

(28) **Non-legend** drugs other than those listed above.

(29) **Tretinoin** topical (e.g. Retin-A) for individuals twenty-six (26) years of age or older.

(30) **Prescription Vitamins**, singly or in combination. Exceptions: Legend prenatal vitamins are covered.

(31) **Prescription supplements** such as minerals, nutrients, fluoride and calcium.

(32) **Therapeutic** devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use.

(34) **No** Coordination of benefits with RX under this Plan.

(35) **No** Shoe Boxing of claims for RX. If prescriptions are paid for at the time of services, claims must be submitted within sixty (60) days for reimbursement.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information and to immediately notify the Employer of any breach of confidentiality with regard to Protected Health Information. Such security measures shall include the implementation and maintenance of reasonable and appropriate administrative, technical, and physical safeguards to protect the security, integrity, confidentiality, and availability of Protected Health Information created, maintained, received, or transmitted by any agent or subcontractor. Any agent or subcontractor whom recives Protected Health Information pursuant to this Health Plan shall comply with additional or modified requirements set forth in any annual guidance as to the security requirements published by the Secretary of Health and Human Services and with the additional requirements of the HITECH Act that relate to security of Protected Health Information. Any agent or subcontractor whom recives Protected Health Information pursuant to this Health Plan shall require any agent or subcontractor that carries out any duties for the agent or subcontractor involving the use, custody, disclosure, creation of, or access to Protected Health Information to enter into a written contract with the agent or subcontractor containing provisions substantially identical to the restrictions and conditions set forth in this paragraph.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the HIPAA Privacy Standards and the HITECH Act.

(4) In the case of a breach of Protected Health Information, the Employer shall notify each Covered Person whose unsecured Protected Health Information has been, or is reasonably believed by the Employer to have been accessed, acquired or disclosed as a result of such breach and the Employer reasonably believes that such breach poses a significant risk of financial, reputational, or other harm to the Covered Person. All notifications required under this paragraph shall be made without unreasonable delay and in no case later than sixty (60) calendar days after the discovery of a breach by the Employer. Notice under this paragraph shall be provided in the following form: (1) written notification by first-class mail to the Covered Person (or the next of kin of the Covered Person if the Covered Person is deceased) at the last known address of the Covered Person or the next of kin, respectively, or, if specified as a preference by the Covered Person, by electronic mail; (2) in the case in which there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes direct written notification to the Covered Person, a substitute form of notice shall be provided, including, in the case that there are ten (10) or more Covered Persons for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Department of Health and Human Services on the

home page of the web site of the Employer or notice in major print or broadcast media, including major media in geographic areas where the Covered Persons affected by the breach likely reside. Such a notice in media or web posting will include a toll-free phone number where a Covered Person can learn whether or not the Covered Person's unsecured Protected Health Information is possibly included in the breach; (3) in any case deemed by the Employer to require urgency because of possible imminent misuse of unsecured Protected Health Information, the Employer, in addition to written notification, may provide information to Covered Persons by telephone or other means, as appropriate. The Employer shall also provide notice to prominent media outlets following the discovery of a breach involving unsecured Protected Health Information of more than 500 Covered Persons. Regardless of the method by which notice is provided to Covered Persons under this paragraph, notice of a breach shall include, to the extent possible, the following: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; (2) a description of the types of unsecured Protected Health Information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code); (3) the steps Covered Persons should take to protect themselves from potential harm resulting from the breach; (4) a brief description of what the Employer is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and (5) contact procedures for Covered Persons to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address. The Employer shall provide notice to the Secretary of the Department of Health and Human Services of any breach that requires notification to any Covered Person pursuant to this paragraph.

(5) The Employer agrees to comply with the request of any Covered Person to restrict the disclosure of his/her Protected Health Information except as otherwise required by law. The Employer further agrees to limit disclosure, use and requests of Protected Health Information, to the extent practicable, to the limited data set (as defined in the Security Standards) or, if needed by the Employer, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively.

(6) The Employer agrees to not solicit or receive any remuneration in exchange for a Covered Persons Protected Health Information unless expressly authorized by the Covered Person or permitted by the HITECH Act or its accompanying regulations. The Employer also agrees to not utilize Protected Health Information in marketing efforts unless such communications are explicitly permitted by the Security Standards,

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

All **Active, Elected officials and Retired Employees** of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Retired Employee of the Employer if the following criteria are met:

A. Employee must have a hire date prior to July 1, 2009
B. Employee and/or dependents coverage must have been in effect a minimum of one (1) year prior to retirement.
C. Employee must have ten (10) continuous years of full-time service with Williamson County Government or the Board of Education and be age fifty-five (55) on his/her date of retirement ***(or)*** the Employee must have thirty (30) continuous years of full-time service with Williamson County Government or the Board of Education and will be allowed continuation of coverage at retirement regardless of age. Leave of absences that occur during this period will be handled in accordance with state and federal laws.

(2) Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 32 hours per week and is on the regular payroll of the Employer for that work.

(3) is in a class eligible for coverage, or an Elected Official of the Board of Education or Williamson County Government.

An elected official will be identified in the "elected officials" class of coverage unless he/she is covered as an employee or dependent for either Williamson County Government or the Board of Education.

If the elected official has other coverage available through the course of his/her regular job or otherwise, the County's Plan will be considered a secondary coverage plan and coordination of benefit will apply.

Tennessee Code Annotated Sections 8-27-301, 8-27-501 and 8-27-601 authorize such coverage for elected officials of the County and Board of Education.

(4) completes the employment Waiting Period of 30 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting

age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age, subject to the provisions of this section.

Full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the month of the attended school term. Proof of full time student status is required each semester. Coverage will not be terminated, for a period not to exceed one year, if the student takes a medically necessary leave of absence from school or serious injury or illness requires a change to part-time status. Extension of coverage due to medically necessary leave or change of status requires certification by student's physician, in writing, that the leave or change in status is medically necessary.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children, Foster Children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The child will be considered dependent upon the Employee for over one-half of his support if the child is in the custody of the Employee and/or the other parent for more than one-half of the year and the child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.